Health, & Welfare Public Service

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THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

59-016370

STATE FILE NUMBER

FILED MAY 15 1959

Registration District No. 317 Primary Registration District No. 59-500 Registrar's No. 1267

1. PLACE OF DEATH a. COUNTY St Louis		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo b. COUNTY St Louis	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St Johns	Inside Limits Yes ☒ No ☐	c. CITY OR TOWN St Johns 4201	Inside Limits Yes ☒ No ☐
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 2908 Walton Rd	Length of stay in 1b 20 yrs	d. STREET ADDRESS (If outside, give location) 2908 Walton Rd	Reside on Farm Yes ☐ No ☐

3. NAME OF DECEASED (Type or print) First DOLORES	Middle	Last TUCCI	4. DATE OF DEATH Month May	Day 7	Year 1959	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐	8. DATE OF BIRTH 11/1/1925	9. AGE (In years last birthday) 33	IF UNDER 1 YEAR Months / Days	IF UNDER 24 HRS. Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Nil	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) St Louis Mo		12. CITIZEN OF WHAT COUNTRY? USA		
13a. FATHER'S NAME Angelo Tucci	13b. MOTHER'S MAIDEN NAME Adela Feo	14. NAME OF HUSBAND OR WIFE -----				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes or No or unknown) No (If yes, give war or dates of service)	16. SOCIAL SECURITY NO. None	17. INFORMANT Address Angedo Tucci 2908 Walton Rd				

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Generalized Carcinomatosis — INTERVAL BETWEEN ONSET AND DEATH: 1 yr.

Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.

DUE TO (b) Primary Carcinoma of Rt. Breast. — 5 yrs.

DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) 170X

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)	
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year		
20d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION / COUNTY / STATE

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

All diseases in Part I must be causally related.

21. I attended the deceased from Aug 1954, to 5-7-59 and last saw her alive on 5-6-59

Death occurred at 1 AM m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) Herman J. Koerber M.D.	22b. ADDRESS 9616 Lackland Rd.	22c. DATE SIGNED 5-7-59

23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 5/9/59	23c. NAME OF CEMETERY OR CREMATORY Sacred Heart	23d. LOCATION (City, town, or county) Florisant	(State) Mo
24. FUNERAL DIRECTOR ADDRESS Ortmann F Home 9222 Lackland Overland Mo	25. DATE RECD. BY LOCAL REG. 5-7-59	26. REGISTRAR'S SIGNATURE John A Murphy MD		

(Licensed Embalmer's Statement on Reverse Side)

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by Sam Stypanovic, Student Embalmer No. 576 working under my personal supervision.

Student Sam Stypanovic Signed A. C. Ortmann

Signature of Student Embalmer

Licensed Embalmer No: 3478

P. O. Address .....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.